Agnes 6/13/13 1105am

414 425 2589 1043 6/7/13 called twice 1/16 left message

Antoine Blackwin SSI 877 60 2856 ? 26401

MEDICAL AND JOB WORKSHEET - ADULT

Please do **not** mail this worksheet to your local office.

Did you know that you can start the application process online? Visit ***www.socialsecurity.gov/applyfordisability*** for more information! Complete this worksheet to get ready for the appointment or when filing online. This worksheet is not the application for Social Security disability benefits. You should bring this worksheet to your appointment or have it with you if your appointment is by telephone.

A. Medical Conditions

List all of the physical or mental conditions (including emotional or learning problems) that limit your ability to work. If you have cancer, please include the stage and type. List each condition separately.

No Immune System - always sick / allergic to everything

	CONDITIONS
1.	Chronic Renal Failure
2.	Chronic Kidney Disease Stage 4 GFR 23
3.	Parathyroid Disease Hormone 14-72 pg/mL is normal
4.	Hypertension / Raynauds Disease
5.	Depression, major - Bi Polar - ADD

I am 154

Auto Immune Disorder

B. If you are not working, when did you stop working? Aug 2011

C. Height without shoes: 5 feet 4 inches **Weight without shoes:** 103 pounds

D. Medical Sources

Please list any doctors, hospitals, clinics, therapists, or emergency rooms you have visited because of your conditions.

NAME	ADDRESS	PHONE NUMBER (with area code)	DATE FIRST SEEN OR ADMISSION DATE	DATE LAST SEEN OR DISCHARGE DATE
Dr Terry Williamson	1061 E. Conmerace Blvd Slinger WI	262 644 2900	1996	4/24/13
Dr Omar Afzal	111 Ann Strt. Waukesha	414 393 9810	1/28/13	2/27/13
Sheila Rotta, RN	9200 W. Wisconsin Ave	414 955 6936		
Froedtert + Medical College of WI	9200 W. Wisconsin Ave	414 805 3666	Placed on List since	Kidney Transplant 10-7-10

E. Medicines

Please list any medicines you take and why you take them. If prescribed, please provide the doctor's name.

NAME OF MEDICINE	WHY YOU TAKE IT	PRESCRIBED BY
Diovan 160mg	To Control Blood Pressure and Hypertension	Omer Afzal
Calcitriol 0.5mg	To help with the Parathyroid Hormone	Omer Afzal
Pantoprazole 40mg	Acid Reducer	Terry Williamson
Adderall 10mg 2x's a day	ADHD + Depression	Terry Williamson

F. Medical Tests

Please list any medical tests you had or are going to have in the future.

NAME OF TEST	PROVIDER WHO SENT YOU	DATE(S)
Labwork Every 8-12wks	Dr Terry Williamson Dr Omar Afzal	Last on 4/24/13 - Next 6/17/13
Physical/OB PAP	Williamson/Ratta	
Mamogram	Sheila KhodaRatta	Aug 2012/Aug 2013
Pelvic Exam	Williamson/Ratta	4/9/13
Monthly Weight/Med Refill	Williamson	5/22/13
Dental Cleaning	Williamson/Ratta	4/13/13 - Cleaning Every 6mos due to Acid Reflux/Vomiting Build

G. Job History

List the jobs (up to 5) that you have had in the 15 years before you became unable to work because of your physical or mental conditions. List your most recent job first.

JOB TITLE (e.g., cook)	TYPE OF BUSINESS (e.g., restaurant)	DATES WORKED FROM Mo/Yr	DATES WORKED TO Mo/Yr	HOURS PER DAY	DAYS PER WEEK	RATE OF PAY Amount	RATE OF PAY Frequency
Operations Cordinate	Airline	9/03	8/11	4-6	4-5	13.02	Every 2 weeks

Bring this worksheet to your appointment or have it with you if your appointment is by telephone. Do not delay filing your application, even if you do not have all of the information. We will help you get any missing information.

EPI/Chart #: _____

Aurora Advanced Healthcare, Inc.

PERMISSION TO DISCUSS MY HEALTH INFORMATION

Dafina Roter Velyov, [redacted]-74, 414 241 6674

Patient Name (Please Print) Date of Birth Phone

To assist me with my healthcare and payment, I give permission to Aurora Advanced Healthcare to discuss the following types of information: (Check as many as apply)

- o **A**ppointments
- o **B**illing Information /Statements/Insurance Claims
- o **C**linical Information
  (diagnosis, prognosis, medications, type of illness, test results, treatment, etc.)
- o Other, Specify _____

I wish to be contacted in the following manner (check all that apply):

o Home telephone _____
oOk to leave message with detailed information oLeave message with call-back number only

oWork telephone _____
oOk to leave message with detailed information oLeave message with call-back number only

oCell phone _____
oOk to leave message with detailed information oLeave message with call-back number only

With the following individuals:

- o Spouse/partner _____ Phone no. _____
- o Son/Daughter _____ Phone no. _____
- o Son/Daughter _____ Phone no. _____
- o Son/Daughter _____ Phone no. _____
- o Mother/Father _____ Phone no. _____
- o Employer _____ Phone no. _____
- o Friend(s) _____ Phone no. _____
- o Other _____ Phone no. _____

If there is medical information you do not want Aurora Advanced Healthcare to share, please list it here

_____

This permission has no expiration unless otherwise noted here _____

I understand that any disclosure carries with it the potential for unauthorized redisclosure and it may no longer be protected by the privacy rule.

I have the right to withdraw this permission at anytime in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization.

I understand it is my responsibility to inform Aurora Advanced Healthcare in writing of any changes to this permission.

If I choose to withdraw this permission <u>OR</u> need to make changes, <u>I must contact</u> the Aurora Advanced Healthcare Medical Information Department at:

(262)532-7061 W180 N11070 River Lane – Germantown, WI 53022
Mailing address - P.O. Box 090996, Milwaukee, WI 53209-0996

SIGNATURE OF PATIENT Dafina Roter Velyov **DATE:** July 17, 2014

5/27/10

Aurora Advanced Healthcare, Inc. Chart # _____

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I, _____, _____
Patient Name Previous Names

_____, _____
(Call When Ready) Phone # Date of Birth

AUTHORIZE DISCLOSURE FROM:

_____
Name of Health Care Provider/Plan/Other

_____
Street Address

_____
City State Zip Code

DISCLOSE PROTECTED HEALTH INFORMATION TO:

_____
Name of Health Care Provider/Plan/Other

_____
Street Address

_____
City State Zip Code

INFORMATION TO BE DISCLOSED:

- ✓ Lab Reports, From _____ To _____
- ____ Imaging Reports (Xray), Date/test _____
- ____ Imaging Films (Xray), Date/test _____
- ____ Clinical Studies, Date/test _____
- ✓ Clinic Notes, From _____ To _____
- ✓ Non-Aurora Advanced Healthcare Medical Information _____
  _____
- ____ Immunizations
- ____ Allergy Records
- ____ Billing/Statement Information
- ____ Results of my pre-placement physical exam which could include drug and/or alcohol screen and/or evidence of physical restrictions
- ____ Oral Communication
- ____ Other, Service and/or dates _____

Aurora Advanced Healthcare, Inc. is not a treatment facility for mental health, developmental disabilities, and alcohol and drug abuse. However, our records may contain information pertaining to such treatment. **We will disclose such information, unless you indicate below that you do not want such information disclosed:**

- ____ Mental Health
- ____ HIV (AIDS) Test Results
- ____ Developmental Disabilities
- ____ Sexually Transmitted Disease
- ____ Alcoholism
- ____ Drug Abuse

Other (Specify): _____

PURPOSE FOR NEED OF DISCLOSURE: (Check applicable categories)

- ____ Further Medical Care – **no fee**
- ____ Changing Physicians – **no fee**
- ✓ Disability Compensation – **fee $**
- ____ Personal Request – **possible fee $**
- ✓ Legal Investigation or Action = **fee $**
- ____ Insurance Claim – **fee $**
- ____ Tax Record – **fee $**
- ____ Other (Specify) _____
- ✓ Workers' Compensation – **fee $**
- ____ Insurance Application – **fee $**
- ____ Economic Need Verification

ALL REQUESTS WILL BE MAILED UNLESS OTHERWISE INDICATED.

Pickup: _____ Needed by: _____

Fax #: _____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

I understand that it is Aurora Advanced Healthcare's expectation that the information released by this authorization will remain confidential. However, I also recognize that the information could be re-disclosed by the recipient and will no longer be protected. I understand that I have the right to revoke/withdraw this authorization in writing, with the exception that this authorization may have already been honored. If I choose to revoke/withdraw this authorization, I must contact the Release of Information Department – Aurora Advanced Healthcare Corporate Office Building (262) 532-7061.

I understand that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign this authorization will not affect my ability to obtain treatment, receive payment or eligibility for benefits.

Expiration Date: This authorization is valid until the following date(s) _____ or event(s) (specify event) _____. If no date or event is specified, this authorization will expire one (1) year from the date signed.

I have had an opportunity to review and understand this authorization. By signing the authorization, I am certifying that it accurately reflects my wishes.

SIGNATURE OF PATIENT/LEGAL REP: Dafna Rose Velgel **DATE:** 7-7-14

If signed by person other than patient, state relationship and authority to do so.

Patient is: o Minor o Incompetent o Disabled o Deceased

Legal Authority (Optional):

- o Legal Guardian
- o Executor of Estate of Deceased
- o Authorized Legal Representative
- o Spouse/Next of Kin of Deceased (Specify relationship) _____
- o Parent
- o Power of Attorney for Healthcare
- o Power of Attorney

T-Mobile: We have received your information and will connect you with a T-Mobile Chat Specialist soon.

Michael C: Hi Dafina! This is Michael, I'll be assisting you today.

You: Hello :)

Michael C: I can only imagine how important it is for you to get copies of your bill and some text messages. I can certainly help you get the copies of your bill, however, printing text messages itself is not an option.

You: does it show the numbers texting back and forth at least ? for usage details? that would be a great help...

You: Thank You soo much

Michael C: Thank you for understanding. Yes, we will send you a detailed bill for these months.

Michael C: Do you need the copy soon? Because we will only be able to reprint the bills through mail.

You: Your a Angel.. your name is fitting for yo!! Thank You again.. do you know about how long it will be until I receive them? and YES :)

You: Mail is fine

You: Im just happy you can retreive them!!!

Michael C: Glad we can help, Dafina. One last thing though, you have a one free reprint, and each additional month will be assessed a $5 fee.

Michael C: You should receive the bill within 5 to 10 business days.

You: no problem... thanks again :)

Michael C: Thank you for your cooperation. Please stay on the session to make sure that I will be sending you the months you need.

Michael C: Your june 2011 bill is for the cycle 05/08/2011 to 06/07/2011. If I send you the June, July, and August bill, you will receive the records from 05/08/2011 to 08/07/2011.

Michael C: Do you have any questions before I process the reprint?

You: I need June 1st to August 31st 2011

Michael C: I see, then you will need the September bill as well. The September bill covers the cycle from 08/08 to 09/07.

Michael C: Would like to proceed in reprinting the June, July, August, and September bill?

You: yes please

Michael C: Alright, I am now working on the request, Dafina.

Michael C: I have sent the request. Rest assured that you will get the copies within 5 to 10 business days.

You: THANK YOU VERY MUCH!!!!

Michael C: It has been a real pleasure! I sure hope you get the info you need from these bills.

Michael C: Would there be anything else I can assist you with?

414 241 6674 only

- Missing 2011 July + August TEXT Records -

- Requested from TMobile again on: Incoming Outgoing Texts

Great help very sweet

10:28pm Lyka 7/13/14

July 1st - August 31st 2011

Billing Cycle

24min 39sec

June 1st - July 8 - Sept 8th 2011

No Charge waived $5 per mo Fees

will take

Submitted 5-10 Business Days

on 7/13/14 @ 10:54pm

I just received the phone records in the mail I had to re request. I will go thru them + send copies to you